

DEPARTMENT OF THE ARMY
MADIGAN ARMY MEDICAL CENTER
Tacoma, Washington 98431-1100

MAMC Regulation
Number 40-111

14 May 2002

Medical Services
USE OF RESTRAINT

1. Purpose. To establish uniform guidelines governing the process of restraint to include assessment for use, alternatives and documentation within Madigan Army Medical Center (MAMC). This policy does not apply to forensic and correction restrictions (prisoners) used for security purposes (such as handcuffs or shackles).

2. References.

a. Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Comprehensive Accreditation Manual for Hospitals, current edition.

b. 42 CFR 482.13 Condition of Participation for Hospitals: Patient's Rights (Health Care Finance Administration (HCFA) Standards).

3. Explanation of Abbreviations and Terms. Abbreviations and special terms used in this regulation are explained in the Glossary.

4. Responsibilities.

a. The Chair, Executive Board of Directors (EBOD) supports initiatives that create an environment minimizing the circumstances that give rise to restraint use and maximizes safety when restraint is used.

b. Chief, Quality Services Division (QSD).

(1) Coordinates quality-control analysis of the use of restraint.

(2) Identifies trends and assists in developing strategies to reduce restraint use.

c. Department Chiefs.

(1) Provide restraint education to physician providers.

(2) Monitor compliance of physicians within their departments.

d. Physicians.

(1) Support the MAMC restraint policy.

(2) Utilize the standard order set, MAMC OP 1179-PS (Patient Restraint Standard Orders) or its electronic equivalent when authorizing the use of restraint.

(3) Assess patients face-to-face in conjunction with ordering restraint.

(4) Discriminate between Restraint for Behavior Management and Restraint Used to Promote Medical/Surgical Healing.

e. Registered Nurses.

(1) Follow this policy when initiating or utilizing restraint.

(2) Initiate restraint according to established criteria in this policy in emergency situations.

(3) Ensure that all clinical staff under their supervision comply with the assessment, reassessment and monitoring parameters outlined when a patient under their care is restrained.

(4) Participate in ongoing education supporting competency in restraint use.

(5) Ensure that competent and trained staff apply and remove restraint.

f. All Staff Members.

(1) Ensure less restrictive alternatives are considered prior to the use of restraint.

(2) Ensure the rights, well being and dignity of the restrained patient are protected and preserved.

(3) Ensure restraint is applied and removed only by competent, trained staff members.

(4) Ensure the restrained patient is assessed and monitored appropriately.

(5) Ensure the restrained patient's needs are met during the restraint episode.

(6) Ensure the restraint episode is properly documented.

(7) Ensure the family of the restrained patient is educated and included/involved in decisions regarding restraint, whenever possible.

5. Policy and Procedures. These policies and procedures apply to every patient and to each episode of restraint.

a. General.

(1) The use of restraint poses a significant risk to the physical and psychological health and the safety of both patient and staff, as well as the psychological health of other individuals who witness the incident. Restraint is an intervention of last resort.

(2) The decision to restrain requires adequate and appropriate clinical justification. Restraint is to be applied for no longer than it is clearly needed and any doubts about the need for restraint should be resolved in favor of an alternative to restraint.

(3) When assessing and planning for the care of the patient, consideration will be given to conditions or symptoms that indicate a need for protective intervention (i.e., restraint). Convenience is not an acceptable reason to restrain a patient. Restraint will not serve as a substitute for adequate staffing to monitor patients. The use of restraint will be predicated on a thorough assessment that examines the patient's medical symptoms and builds upon a care plan that will meet the patient's needs.

(4) The use of a medication as a chemical restraint is inappropriate.

b. Educating Patients and Family Members.

(1) Upon admission and otherwise as appropriate, patients and their family members will be informed of the organization's policy on restraint through the use of informal briefings and/or informational handouts.

(2) In cases in which the patient has consented to have the family kept informed regarding his or her care and the family has agreed to be notified, staff will attempt to contact the family promptly to inform them of the application of restraint.

(3) Verbal agreement to the use of restraint received from the patient or the patient's legal representative affirms respect for patient autonomy, eliminates the dimension of sacrifice of personal liberty and is strongly encouraged. It is sufficient to obtain agreement once per hospitalization providing the behavior leading to the application of restraint remains constant (e.g., pulling of tubes). If a new behavior is encountered (e.g., attempts at self-harm in a patient who previously agreed to restraint to prevent the pulling of tubes), agreement for restraint should be obtained for the new behavior. Agreement is consistent with the patient's and family's involvement in care decisions and is obtained through patient and family education. Verbal agreement shall be documented in the Medical Record.

c. Preventive Strategies and Use of Alternatives. Efforts will be made to avoid the use of restraint. Alternatives to restraint are summarized in Appendix A. The alternatives include:

(1) Correcting or improving factors such as oxygenation, metabolism, infection, sleep deprivation, pain, alcohol or drug withdrawal and adverse reactions to medications.

(2) Modifying environmental factors such as light and noise levels, distractions (television or radio), visual orientation cues (clocks, calendars, open window curtains) and eliminating fall hazards.

(3) Anticipating and assisting with self-care needs such as toileting, nutrition, hydration and hygiene.

(4) Providing supervision by placing the patient in a bed close to the nursing station or having family or staff remain with the patient.

(5) Eliminating irritating tubes and lines as soon as possible.

(6) Providing alarms for patients who get out of bed or chairs unassisted.

(7) Promoting exercise and ambulation.

(8) Enlisting the services of Physical and Occupational Therapy to assist with safe ambulation, activities of daily living and increasing strength and endurance.

(9) Providing distraction.

(10) Using stop signs, curtains or other visual barriers to block access to restricted areas.

d. Patient Factors. Before the application of restraint, and at intervals thereafter, the patient will be assessed for:

(1) Mental status to include, at a minimum, orientation and arousal.

(2) The ability to understand and comply with the treatment plan, in a manner that is developmentally and language appropriate.

(3) The potential for drug or alcohol withdrawal.

(4) The presence of medications or illnesses that could alter mental status.

(5) Irritating lines, tubes, or dressings that might be discontinued.

(6) Pre-existing medical conditions or physical disabilities that would place the patient at greater risk during restraint.

(7) Oxygenation, comfort, ability to rest and environmental factors.

e. Initiation of Restraint.

(1) Restraint will be authorized only when alternative strategies have proven ineffective and the patient demonstrates one or more of the behaviors listed below.

(a) Removal of or pulling at dressings, lines and tubes.

(b) Ambulation without assistance when at risk for falls, wandering or self-injury due to a non-weight bearing status.

(c) Display of assaultive, combative or destructive behaviors.

(d) Attempts to harm self, others, property or the therapeutic milieu.

(2) A doctor's order (MAMC OP 1179-PS or electronic equivalent) will be obtained prior to the application of restraint, unless a registered nurse authorizes its emergent use because the patient poses an immediate danger to self or others (i.e., restraint for behavior management). In all circumstances, a doctor's order will be obtained within one hour of the application of restraint.

(3) When restraint is used for behavior management, a Licensed Independent Practitioner (LIP) will conduct a face-to-face assessment within one hour from the time of the application of restraint.

(4) When restraint is used to promote medical/surgical healing, a LIP will conduct a face-to-face assessment as soon as is possible, but no later than 24 hours from the time of the application of restraint.

f. Choice of Restraint Device. Use the least restrictive type of restraint as outlined in Table 1. Use only equipment specifically designed for restraint.

Table 1: Restraint Device Selection

TYPE OF DEVICE	LEAST TO MOST RESTRICTIVE MEASURE			
	BODY ONLY	ONE LIMB	MULTIPLE LIMBS	LIMBS AND BODY
	➡	➡		➡
Side Rails	0			
Mitts		0	0	0
Soft Limb Restraints		0	0	
Soft Belt	0			0
Vest	0			
Leather Cuffs		0	0	0

g. Orders for Restraint.

(1) Orders for restraint are defined by specific time limits based upon the age of the patient and the type of restraint applied as noted in Table 2. If restraint needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion will be obtained from a LIP. Each order authorizes a new restraint episode. Time-limited orders do not mean that restraint must be applied for the entire length of time for which the order is written. Restraint should be discontinued as soon as the patient meets the behavior criteria for its discontinuation.

Table 2: Time Limits for Restraint

Indication for Restraint	Patient Age	Frequency With Which New Order Required
Behavior Management	> 17 (adult)	4 hours
Behavior Management	9 - 17 (adolescent)	2 hours
Behavior Management	< 9 (children)	1 hour
Medical/Surgical Healing	All ages	Once per calendar day

(2) When restraint is terminated before the time-limited order expires, that original order can be used to reapply the restraint or seclusion if the patient is at imminent risk of physically harming himself/herself or others and nonphysical interventions are not effective. However, if the original order has expired, a new order for restraint is required.

(3) Orders for the use of restraint or seclusion are not written as a standing order or on an as needed basis (prn).

h. Patient Monitoring. The purpose of monitoring a patient in restraint is to ensure the patient's physical safety.

(1) Staff members who monitor the patient in restraint will:

(a) Attend to the physical and emotional well being of the patient.

(b) Validate that the patient's rights, dignity and safety are maintained.

(c) Determine whether less restrictive methods are possible.

(d) Observe changes in the patient's behavior or clinical condition that necessitate the removal of restraints.

(e) Ensure that the restraint has been appropriately applied, removed or reapplied.

(2) The frequency of monitoring is determined by the indication for the application of restraint.

(a) Assigned staff member will monitor patients restrained for behavior management through continuous in-person observation (line-of-sight).

(b) The patient restrained to promote medical/surgical healing will be monitored, at a minimum, every two hours.

i. Patient Assessment. Periodic assessment is conducted to identify specific restraint-related patient needs.

(1) Staff members who assess the patient in restraint and document relevant findings into the health record will:

(a) Take vital signs and interpret their relevance to the physical safety of the patient in restraint.

(b) Identify nutritional/hydration needs.

(c) Check circulation and range of motion in the extremities.

(d) Address hygiene and elimination.

(e) Address physical and psychological status and comfort.

(f) Assist the patient in meeting behavior criteria for the discontinuation of restraint.

(g) Recognize readiness for the discontinuation of restraint.

(h) Recognize when to contact a medically trained LIP in order to evaluate and/or treat the patient's physical status.

(2) The frequency of assessment and its documentation is determined by the indication for the application of restraint:

(a) Patients restrained for behavior management will be assessed every 15 minutes.

(b) Patients restrained to promote medical/surgical healing will be assessed, at a minimum, every two hours.

j. Patient Reevaluation. Prior to each new episode of restraint, the patient will receive a face-to-face reevaluation by the LIP responsible for the patient's care. The LIP will:

(1) Review with staff the physical and psychological status of the patient.

(2) Determine whether restraint should be continued.

(3) Supply staff with guidance in identifying ways to help the patient regain control in order for restraint or seclusion to be discontinued.

(4) Supply an order.

k. Documentation.

(1) For all types of restraint, the health record will include the following supportive documentation, as appropriate:

(a) The circumstances that led to the application of restraint.

(b) A statement regarding the failure of nonphysical interventions.

- (c) A rationale for the type of restraint selected.
 - (d) Behavior criteria for discontinuation of restraint.
 - (e) Written orders for use.
 - (f) Observations derived from monitoring of the patient (continuous with restraint for behavior management versus every two hours for restraint to promote medical/surgical healing).
 - (g) Results of periodic patient assessments (every 15 minutes with restraint for behavior management versus every two hours for restraint to promote medical/surgical healing).
 - (h) A summary of each face-to-face evaluation and reevaluation of the patient by the LIP.
 - (i) Any assistance provided to the patient to help him or her meet the behavior criteria for discontinuation of restraint.
 - (j) Any injuries that were sustained and any treatments rendered for said injuries.
 - (k) Notification of the patient's family, when appropriate.
- (2) When restraint is used for behavior management, the documentation will also include:
- (a) Indication that the patient and/or family was informed of the organization's policy on the use of restraint.
 - (b) A summary of any pre-existing medical conditions or any physical disabilities that would place the patient at greater risk during restraint.
 - (c) Specific comments regarding any patient-held advance directives with respect to behavioral health care.
 - (d) Information relevant to any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint.
 - (e) A summary of the debriefing session held with the patient and/or family members. The debriefing will be held as soon as is possible, but no longer than 24 hours after the episode.
1. Reporting of Restraint for Behavior Management. Use MAMC Form 1709-N (Nursing Unit 24 Hour Report) to notify the clinical leadership of any instance in which a patient remains in restraint for behavior management for more than 12 hours, or experiences two or more separate episodes of restraint of any duration within 12 hours. Thereafter, the leadership is notified every 24 hours if either of the above conditions continues.
- m. Training. All staff who are authorized to physically apply restraint, assess or monitor the patient in restraint, or who are authorized to initiate

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restraint and/or perform evaluations/reevaluations will receive training for restraint procedures, to include proper documentation. This will be accomplished through a variety of channels to include nursing orientation, the Madigan intranet and graduate medical education. Initial and ongoing competency will be documented in the individual's six-part education folder as appropriate.

The proponent agency for this regulation is the Office of the Deputy Commander for Clinical Services. Users are invited to send comments for suggested improvement to the Deputy Commander for Clinical Services.

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Electronic Bulletin Board

Appendix A
Alternatives to Restraint

Physical Interventions

- Provide exercise and activities (arts/crafts/hobbies/coloring books/crossword puzzles/videos/games/books and magazines)
- Anticipate/provide for basic needs such as hunger, thirst and toileting
- Promote normal sleep patterns
- Encourage relaxation techniques
- Listen to the patient and encourage the expression of feelings
- Obtain the patient's permission to use safety measures such as lap belts

Psychological Interventions

- Talk to your patient, not "over" him or her
- Explain all procedures and acknowledge the fear of the unknown
- Orient the patient to his or her surroundings
- Encourage the companionship of others such as family, friends, church members or volunteers
- Hold or cuddle infants and young children as appropriate

Physiological Interventions

- Review medications for side effects and interactions
- Review lab results (e.g., electrolytes, complete blood count, blood gas)
- Conduct a physiological assessment
- Collaborate with other healthcare members and revise the treatment plan
- Institute a toileting program
- Institute a bowel program

Spiritual Interventions

- Contact the hospital or unit chaplain
- Offer the sacraments of Communion, Reconciliation and Anointing of the Sick

Environmental Interventions

- Use 1:1 communication to inform the patient of measures taken to promote safety
- Use cushions or pads to protect the patient or consider alternate bedding solutions
- Locate the patient in proximity to the nurse's station
- Maintain appropriate lighting
- Use a Geri chair or other adaptive support
- Be sensitive to ambient noise levels
- Remove clutter and obstacles that could injure the patient
- Assure that items such as the nurse call light and items to facilitate toileting needs are within reach
- Position lines and tubes to be least obtrusive
- Use bedrails ONLY when an individualized assessment supports their use

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- Attend to the impact of disruptions such as visitors and examinations or procedures

Appendix B
Restraint Quick Use Reference

<i>What type of restraint are we talking about?</i>	Restraint for Behavior Management (Psychiatry Unit Only)	Restraint for Behavior Management (Any Other Setting)	Restraint Used to Promote Medical/Surgical Healing (Any Setting)
<i>What is the purpose of the restraint?</i>	Used in an emergency when a patient's behavior is violent or aggressive and poses a threat to the patient or staff.		Used on a non-combative, otherwise cooperative patient non-emergently to alter a behavior that retards healing.
<i>Where is this type of restraint used?</i>	Any clinical setting.		Any clinical setting.
<i>How soon after the application of restraint is a doctor's order needed?</i>	Within 1 hour.		Within 1 hour.
<i>Once restraint is applied, how soon must the licensed independent provider (LIP) conduct a face-to-face assessment?</i>	Within 1 hour.		Within 24 hours.
<i>How long is the original doctor's order valid?</i>	Over age 17: 4 hours Ages 9-17: 2 hours Below age 8: 1 hour		One calendar day.

<i>How often is a new doctor's order needed if restraint is to continue beyond the period authorized by the original doctor's order?</i>	Over age 17: Every 4 hours Ages 9-17: Every 2 hours Below age 8: Every hour	Each calendar day.
<i>How often must the LIP conduct a face-to-face reassessment of the patient?</i>	Each time a new order is written.	Each time a new order is written.
<i>How often must the nursing staff monitor the patient for things like physical and emotional well being and patient safety?</i>	Continuous (line of sight) monitoring.	No less than every 2 hours.
<i>How often must the nursing staff assess the patient for things like vital signs, circulation, hygiene, and comfort?</i>	Every 15 minutes.	No less than every 2 hours.
<i>How often do the findings from the nursing staff's monitoring and assessment need to be documented?</i>	Every 15 minutes.	No less than every 2 hours.

<p><i>For each episode of restraint, what must be documented into the health record?</i></p>	<p>For all forms of restraint in all settings:</p> <ul style="list-style-type: none"> • The circumstances that led to the application of restraint. • Nonphysical interventions that failed. • Rationale for the type of restraint selected. • Criteria for discontinuation of restraint. • Written orders for use. • Observations derived from monitoring and assessment of the patient. • Summary of each face-to-face evaluation by the LIP. • Assistance provided to the patient to help him or her meet the behavior criteria for discontinuation of restraint. • Any restraint-related injuries or treatments. • Notification of the patient's family, when appropriate.
<p><i>Are there unique items that must be documented when restraint is applied on the Psychiatric Ward?</i></p>	<p>Psychiatry Unit Only:</p> <ul style="list-style-type: none"> • Indication that the patient and/or family was informed of the organization's policy on the use of restraint. • Summary of any pre-existing medical conditions or any physical disabilities that would place the patient at greater risk during restraint. • Content of any patient-held advance directives with respect to behavioral health care. • Relevant history of sexual or physical abuse that would place the patient at greater psychological risk during restraint. • A summary of the debriefing session held with the patient and/or family members.

Glossary

Section I Abbreviations

LIP
Licensed Independent Practitioner

Section II Special Terms

Adaptive Support

Use of measures intended to allow a patient maximum normative body function. Examples include orthopedic applications, braces, wheelchairs, helmets, or other appliances/devices used to support the patient and prevent harm.

Chemical Restraint

The use of any psychoactive medication that is not a usual or customary part of a medical diagnostic or treatment procedure, and that is used to restrict a patient's freedom of movement.

Competent, Trained Staff Members

Staff members who have completed training and have passed both a written and practical examination on the safe application of, release from, monitoring of, and alternatives to restraint.

Licensed Independent Practitioner (LIP)

An LIP is an individual who is recognized by hospital policy as having the independent authority to order restraints for patients. This includes residents providing care under the auspices of a graduate medical education program accredited by the Accreditation Council on Graduate Medical Education.

Medical Immobilization

Use of measures that are inherent and customary to certain medical, dental, diagnostic or surgical procedures. Such measures include, but are not limited to, surgical positioning, intravenous (IV) arm boards or devices used to stabilize a patient during radiotherapy or radiographic procedures.

Physical Restraint

Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to:

Arm restraints, leg restraints, hand mitts, soft ties or vests, lap cushions, and lap trays that a patient cannot easily remove.

Side rails that keep a patient from voluntarily getting out of bed.

Tucking in or using Velcro to hold a sheet, fabric, or clothing tightly so that a patient's movement is restricted.

Devices used in conjunction with a chair, such as trays, tables, bars or belts, that a patient cannot easily remove and that prevent the patient from rising.

Placing a patient in a chair that prevents him or her from rising.

Placing a chair or bed so close to a wall that the wall prevents the patient from rising out of the chair or voluntarily getting out of bed.

Restraint

The direct application of physical force to a patient, without the patient's permission, to restrict his or her freedom of movement. The physical force may be human, a mechanical device, or a combination thereof. This definition does not apply to interactions with patients that are brief and focus on redirection or assistance in activities of daily living, such as hygiene.

Restraint for Behavior Management

The application of physical restraint in an emergency situation in which the patient's behavior is violent or aggressive and poses a threat to the patient or staff.

Restraint to Promote Medical/Surgical Healing

The application of physical restraint in non-emergent situations to a non-combative, otherwise cooperative individual exhibiting a behavior that retards healing.